		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034066

Facility Name: St Mary's Square Living Center

Address: 239 South Cherry Street (Number) Galesburg (City) 61401 (Zip Code)

County: Knox

Telephone Number: (309) 343-4101 **Fax #** (309) 343-4118

HFS ID Number: 37-1223609001

Date of Initial License for Current Owners: 7/15/88

Type of Ownership:

[X] VOLUNTARY,NON-PROFIT		[ ] PROPRIETARY		[ ] GOVERNMENTAL	
	[X] Charitable Corp.		[ ] Individual		[ ] State
	[ ] Trust		[ ] Partnership		[ ] County
IRS Exemption Code 501(c)(3)			[ ] Corporation		[ ] Other
			[ ] "Sub-S" Corp.		
			[ ] Limited Liability Co.		
			[ ] Trust		
			[ ] Other		

In the event there are further questions about this report, please contact:
Name: Ron Wilson **Telephone Number:** (309) 343-1550

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/04 to 06/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Bobby Dillard
(Title) Administrator

Paid Preparer

(Signed) See Attached Independent Accountant's Report (Date)
(Print Name and Title) McGladrey & Pullen, LLP
117 E Main Street, Suite 210
(Firm Name & Address) P.O. Box 1070
Galesburg, IL 61401
(Telephone) (309) 342-1175 Fax # (309) 342-7816

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/04 Ending: 06/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	255	Intermediate (ICF)	255	93,075	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	255	TOTALS	255	93,075	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	75,602	577		76,179	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	75,602	577		76,179	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.85%

D. How many bed-hold days during this year were paid by the Department?
991 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/80

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/15/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified ____ and days of care provided ____

Medicare Intermediary NA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/05 Fiscal Year: 06/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Mary's Square Living Center # 0034066 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	419,978	36,892	18,000	474,870		474,870		474,870			1
2	Food Purchase		392,292		392,292	(11,007)	381,285		381,285			2
3	Housekeeping	316,688	47,554		364,242		364,242		364,242			3
4	Laundry	165,354	35,363		200,717		200,717		200,717			4
5	Heat and Other Utilities			241,433	241,433		241,433		241,433			5
6	Maintenance	165,095	113,301	68,373	346,769		346,769		346,769			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,067,115	625,402	327,806	2,020,323	(11,007)	2,009,316		2,009,316			8
	B. Health Care and Programs											
9	Medical Director			18,600	18,600		18,600		18,600			9
10	Nursing and Medical Records	3,113,604	116,601	24,433	3,254,638		3,254,638		3,254,638			10
10a	Therapy			13,575	13,575		13,575		13,575			10a
11	Activities	99,247	23,642	52,008	174,897		174,897	(31,890)	143,007			11
12	Social Services	88,869		1,030	89,899		89,899		89,899			12
13	CNA Training											13
14	Program Transportation			1,073	1,073	9,774	10,847		10,847			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,301,720	140,243	110,719	3,552,682	9,774	3,562,456	(31,890)	3,530,566			16
	C. General Administration											
17	Administrative	84,911			84,911		84,911		84,911			17
18	Directors Fees			9,485	9,485		9,485		9,485			18
19	Professional Services			492,876	492,876		492,876		492,876			19
20	Dues, Fees, Subscriptions & Promotions			28,819	28,819		28,819	(40)	28,779			20
21	Clerical & General Office Expenses	146,453	41,419	7,276	195,148		195,148		195,148			21
22	Employee Benefits & Payroll Taxes			1,190,509	1,190,509	11,007	1,201,516		1,201,516			22
23	Inservice Training & Education			1,761	1,761		1,761		1,761			23
24	Travel and Seminar			3,512	3,512		3,512	(915)	2,597			24
25	Other Admin. Staff Transportation			19,547	19,547	(9,774)	9,773		9,773			25
26	Insurance-Prop.Liab.Malpractice			125,060	125,060		125,060		125,060			26
27	Other (specify):* **Bad Debt**			7,846	7,846		7,846	(7,846)				27
28	**TOTAL General Administration**	231,364	41,419	1,886,691	2,159,474	1,233	2,160,707	(8,801)	2,151,906			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,600,199	807,064	2,325,216	7,732,479		7,732,479	(40,691)	7,691,788			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Mary's Square Living Center #0034066 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			105,037	105,037		105,037	213,909	318,946			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							361,842	361,842			32
33	Real Estate Taxes							214,245	214,245			33
34	Rent-Facility & Grounds			701,462	701,462		701,462	(701,462)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* See attached Sch III							54,517	54,517			36
37	**TOTAL Ownership**			806,499	806,499		806,499	143,051	949,550			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			534,911	534,911		534,911		534,911			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			534,911	534,911		534,911		534,911			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,600,199	807,064	3,666,626	9,073,889		9,073,889	102,360	9,176,249			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/04 Ending: 06/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,846)	V-27		24
25	Fund Raising, Advertising and Promotional	(40)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule IV	(32,805)	V-11		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (40,691)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	143,051		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 143,051		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 102,360		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St Mary's Square Living Center

ID# **0034066**

Report Period Beginning: **07/01/04**

Ending: **06/30/05**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number St Mary's Square Living Center **#** 0034066 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **St Mary's Square Living Center** **# 0034066** **Report Period Beginning:** **07/01/04** **Ending:** **06/30/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	143,051	0	0	0	0	0	0	0	0	0	143,051	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	143,051	0	0	0	0	0	0	0	0	0	143,051	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	143,051	0	0	0	0	0	0	0	0	0	143,051	45

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Community Residential Centers, Inc.	100%			CRC Cherry Street Facility, LLC		
(Non profit organization)					Galesburg	Lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	$ 701,462	CRC Cherry Street Facility, LLC	N/A	$ 844,513	$ 143,051	1
2	V				(Sole member is Community Residential Centers, Inc.)				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 701,462			$ 844,513	$ * 143,051	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Stanley Sydlowski, D.D.S.	President	Director	None	N/A	N/A	N/A	Board mtgs	$ 2,000	18-3	1
2	Charles D. Westbay	Secretary	Director	None	N/A	N/A	N/A	Board mtgs	2,000	18-3	2
3	Gary Bruington	Director	Director	None	N/A	N/A	N/A	Board mtgs	2,000	18-3	3
4	Valerie Flacco	Director	Director	None	N/A	N/A	N/A	Board mtgs	2,000	18-3	4
5											5
6											6
7						Training and meeting expenses			1,485	18-3	7
8						Less: Non-allowable out-of-state travel			0	18-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 9,485		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/04 Ending: 06/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/04 Ending: 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC Commercial						$	$			$	1
2	Mortgage Corporation		X	Facility Purchase	$39,717.00	9/1/03	6,164,400	5,977,784	10/1/2028	6.0000	361,842	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$39,717.00		$ 6,164,400	$ 5,977,784			$ 361,842	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,164,400	$ 5,977,784			$ 361,842	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 37,772 **Line #** 26

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number St Mary's Square Living Center **#** 0034066 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 189,950	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 217,295	2
3. Under or (over) accrual (line 2 minus line 1).	$ 27,345	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 186,900	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 214,245	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	108,635	8
2001	114,801	9
2002	125,484	10
2003	126,213	11
2004	182,165	12

Real estate tax accrual is based on estimated tax expense. Line 2, real estate taxes paid, is the entire amount of the 2003 assessment and one-half of the 2004 assessment. In September 2003, related not-for-profit lessor purchased facility and is in the process of applying for real estate tax exemption.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Mary's Square Living Center COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0034066

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	9915233010	239 S. Cherry Galesburg, IL	$ 177,810.62	$ 177,810.62
2.	9915233008	239 S. Cherry Galesburg, IL	$ 591.24	$ 591.24
3.	9915233009	262 S Prairie St Galesburg, IL	$ 3,763.18	$ 3,763.18
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 182,165.04	$ 182,165.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/04 Ending: 06/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 131,192 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 4 and 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	120,682	2003	$ 180,000	1
2	Facility	11,210	2003	4,000	2
3	TOTALS	131,892		$ 184,000	3

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	255		2003		$ 6,220,000	$ 207,333	30	$ 207,333	$	$ 362,833	4
5			2003		131,518	6,576	20	6,576		10,412	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Garage addition, sidewalk, furnace, elevator			1988	46,740	781	15-20	781		44,371	10
11	Sprinkler, roof repair			1989	29,422	1,455	20-25	1,455		22,844	11
12	Water chiller repair, boiler repair			1990	11,633	641	15-20	641		9,732	12
13	Roof repair, roofing			1991	49,477	2,474	20	2,474		35,536	13
14	Heater/furnace			1992	2,505	167	15	167		2,115	14
15	Windows, sidewalk			1993	7,150	476	15	476		5,758	15
16	Paving, plumbing, boiler equipment, roofing			1994	30,695	1,822	10 to 20	1,822		21,991	16
17	A/C Chiller, tuckpoint, roofing, transformer, elevator equip,			1995	102,052	4,771	15 to 25	4,771		46,178	17
18	Alarm electic work, water heater, door closers, A/C units, stucco work			1996	62,518	4,112	10 to 25	4,112		36,837	18
19	A/C units, fire alarm system, paving			1997	62,969	7,274	8 to 15	7,274		55,597	19
20	Fire alarm, paving, condesate ret. System			1998	16,340	1,675	8 to 15	1,675		11,946	20
21	Coils & stats, fire alarm, commercial door			1999	62,346	6,101	10 to 15	6,101		35,533	21
22	Kitchen upgrade, air conditioner rep, countertop, hall handle rep, HVAC			2000	30,547	2,332	10 to 15	2,332		11,730	22
23	Patio			2002	12,679	634	20	634		1,955	23
24	Elevator renovation			2002	64,541	3,227	20	3,227		8,605	24
25	Air handler			2003	22,100	1,105	20	1,105		2,394	25
26	Concrete construction			2003	12,300	615	20	615		1,281	26
27	Vinyl flooring			2003	3,610	361	10	361		722	27
28	Patio construction			2003	8,614	574	15	574		1,053	28
29	Canopy			2004	9,494	633	15	633		791	29
30	Entry remodeling			2004	47,112	3,141	15	3,141		4,188	30
31	Ceramic flooring			2004	23,779	1,189	20	1,189		1,387	31
32	Wallcoverings			2004	2,898	580	5	580		628	32
33	Kitchen tray slide			2004	5,143	343	15	343		486	33
34	Fire sprinkler upgrade-entry			2004	3,390	136	25	136		147	34
35	Low E windows			2004	2,591	173	15	173		187	35
36	Window awning			2004	920	61	15	61		67	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Water Heater	2005	$ 4,632	$ 116	10	$ 116	$	$ 116	37
38	Hi low manifold system	2005	1,559	39	10	39		39	38
39	Fire alarm system upgrade	2005	8,304	69	10	69		69	39
40	Lounge wiring, plumbing, HVAC	2004	31,730	1,587	20	1,587		1,587	40
41	Entryway flashing	2004	1,224	112	10	112		112	41
42	Chiller coil replacement	2004	8,250	504	15	504		504	42
43	Boiler piping	2004	4,873	142	20	142		142	43
44	Water heater, wiring and plumbing	2004	9,225	538	10	538		538	44
45	Carpet	2004	978	196	5	196		196	45
46	Water Heater	2004	3,750	344	10	344		344	46
47	Elevator hydraulic piston replacement	2004	16,595	484	20	484		484	47
48	Tile installation (vinyl)	2005	2,000	83	10	83		83	48
49	Canopy carpentry	2004	16,967	1,131	15	1,131		1,131	49
50	Canopy	2004	21,168	1,176	15	1,176		1,176	50
51	Vinyl flooring	2004	15,754	1,313	10	1,313		1,313	51
52	Front entryway	2004	126,978	6,349	15	6,349		6,349	52
53	Painting	2004	2,944	491	5	491		491	53
54	Painting	2004	2,128	319	5	319		319	54
55	Door closers	2004	2,276	152	10	152		152	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,366,418	$ 275,907		$ 275,907	$	$ 752,449	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 542,147	$ 29,330	$ 29,330	$	5-20 yrs	$ 396,885	71
72	Current Year Purchases	25,876	2,574	2,574		5-15 yrs	2,574	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 568,023	$ 31,904	$ 31,904	$		$ 399,459	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See Attached Schedule I	See Attached Schedule I	See Attached	$ 201,024	$ 11,135	$ 11,135	$	4 yrs	$ 159,852	76
77			Schedule I							77
78										78
79										79
80	TOTALS			$ 201,024	$ 11,135	$ 11,135	$		$ 159,852	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,319,465	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 318,946	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 318,946	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,311,760	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Related Party Lease
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$ N/A
13.	/2007	$ N/A
14.	/2008	$ N/A

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ N/A Description: N/A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	120
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	120

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
HOURS PER CNA	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		36,421		36,421
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 36,421	$	$ 36,421
10	SUM OF line 9, col. 1 and 2 (e)	$ 36,421			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	21
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	21

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number St Mary's Square Living Center # 0034066 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 958,930	$ 1,003,460	1
2	Cash-Patient Deposits	10,418	10,418	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	1,313,543	1,313,543	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	116,155	116,155	5
6	Prepaid Insurance	81,440	88,940	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interdivision receivable	6,101,754	6,101,754	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,582,240	$ 8,634,270	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,161,029	1,161,029	12
13	Land		184,000	13
14	Buildings, at Historical Cost		6,351,518	14
15	Leasehold Improvements, at Historical Cost	1,014,900	1,014,900	15
16	Equipment, at Historical Cost	769,047	769,047	16
17	Accumulated Depreciation (book methods)	(938,515)	(1,311,760)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule V		921,614	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,006,461	$ 9,090,348	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,588,701	$ 17,724,618	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 352,479	$ 355,740	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,418	10,418	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	274,844	274,844	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,392	24,392	31
32	Accrued Real Estate Taxes(Sch.IX-B)		186,900	32
33	Accrued Interest Payable		29,889	33
34	Deferred Compensation	11,130	11,130	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Health Insurance	55,220	55,220	36
37	Payable to Lessor	27,471		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 755,954	$ 948,533	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,977,784	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,977,784	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 755,954	$ 6,926,317	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,832,747	$ 10,798,301	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,588,701	$ 17,724,618	48

***(See instructions.)**

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 9,801,886	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,801,886	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	49,430	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Unrealized loss on investments**	(18,569)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 30,861	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 9,832,747	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,930,468	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,930,468	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	36,421	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 36,421	23
	D. Non-Operating Revenue		
24	Contributions	23,678	24
25	Interest and Other Investment Income***	100,862	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 124,540	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income	31,890	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 31,890	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,123,319	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,020,323	31
32	Health Care	3,552,682	32
33	General Administration	2,159,474	33
	B. Capital Expense		
34	Ownership	806,499	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	534,911	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,073,889	40
41	**Income before Income Taxes (line 30 minus line 40)****	49,430	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 49,430	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,080	$ 61,461	$ 29.55	1
2	Assistant Director of Nursing	1,217	1,309	27,488	21.00	2
3	Registered Nurses	5,372	5,776	105,527	18.27	3
4	Licensed Practical Nurses	23,207	24,954	390,527	15.65	4
5	CNAs & Orderlies	204,702	220,109	2,018,401	9.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	7,426	7,984	99,247	12.43	9
10	Activity Assistants					10
11	Social Service Workers	6,649	7,150	88,869	12.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,183	43,208	419,978	9.72	15
16	Dishwashers					16
17	Maintenance Workers	12,524	13,466	165,095	12.26	17
18	Housekeepers	30,022	32,282	316,688	9.81	18
19	Laundry	15,347	16,502	165,354	10.02	19
20	Administrator	1,920	2,080	84,911	40.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,870	14,914	146,453	9.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	35,487	38,158	483,846	12.68	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,978	3,202	26,354	8.23	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	402,864	433,174	$ 4,600,199 *	$ 10.62	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	***	$ 18,000	1-3	35
36	Medical Director	***	18,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	***	8,243	10-3	39
40	Physical Therapy Consultant	***	1,485	10a-3	40
41	Occupational Therapy Consultant	***	4,575	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	***	7,515	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	***	1,030	12-3	45
46	Other(specify) Dental Consultant	***	5,055	10-3	46
47	Psychological consultant	***	11,135	10-3	47
48	*** Monthly Fee				48
49	TOTAL (lines 35 - 48)		$ 75,638		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Bobby Dillard	Administrator	None	$ 84,911
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,911

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RFMS, Inc.	Administrative Services	$ 279,510
Community Living Options, Inc.	Support Services	86,460
Crain, Miller & Associates	Legal Services	6,705
Schiff Hardin LLP	Legal Services	25,514
McGladrey & Pullen, LLP	Accounting Services	56,080
RSM McGladrey, Inc.	Accounting Services	5,980
Legat Architects	Architect	32,627
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 492,876

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 176,998
Unemployment Compensation Insurance	18,302
FICA Taxes	347,919
Employee Health Insurance	594,179
Employee Meals	11,007
Illinois Municipal Retirement Fund (IMRF)*	
401(k)	33,976
Other Employee Benefits	19,135
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,201,516

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	19,288
Health Care Worker Background Check	2,295
(Indicate # of checks performed 229)	
Subscriptions	6,338
IHCA Dues	
Advertising - Promotion	40
Other Licenses and Fees	858
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(40)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,779

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Staff use of personal vehicle on facility	
business and meals (under $250 per	
travel voucher)	
Seminar Expense	3,512
Less: Non-allowable out -of-state travel	(915)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,597

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Mary's Square Living Center # 0034066 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Mary's Square Living Center **#** 0034066 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **9 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,554** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **534,911**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,007** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey & Pullen, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit report has not been completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.